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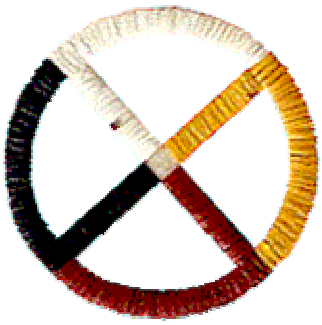

"ONE-HHS" PROPOSALS AND THE PRESIDENTS MANAGEMENT INITIATIVE

Part of the charge given to the RIW is to identify how Indian health reforms fit into the President's Management Agenda and the HHS restructuring initiative called One-HHS. The President's Management Agenda is a Government-wide reform to make the Federal Government citizen-centered, results-oriented, and market-based. The RIW members believe the IHS has already addressed many of the President's goals by reforms implemented in recent years.

HHS Consolidation Proposals

The One-HHS initiative consolidates some functions now carried out in all HHS agencies and moves them to the Departmental level. The purposes of One-HHS are to achieve economies of scale, communicate with one voice, and to save money by reducing FTE in all HHS agencies. To save money, the HHS wants to reduce the number of government workers (full-time equivalents or FTE). For IHS, this means a reduction of 100 FTEs by the end of FY 2003 with more to follow in subsequent years. The proposed consolidations of IHS functions into HHS have caused some concern among RIW members. In this report, the RIW shares the concerns of Indian Country and presents some alternatives. The RIW members believe their recommendations respond to the President's Management Agenda overall.

The RIW strongly supports the HHS national goal to eliminate health disparities between American Indian and Alaska Native people and other Americans. The Workgroup's long-range vision for Indian health fits perfectly with this national goal and with the goals of Congress as expressed in the Indian Health Care Improvement Act. However, the HHS initiatives can diminish the goal by decreasing IHS resources, which is already under funded. The consolidations will make the gap worse, not better. The HHS must reconsider any restructuring actions that would result in counter-productive funding reductions for Indians and consider reinvesting some of the HHS restructuring savings to eliminate the funding disparities for Indian health.

The HHS is striving to improve efficiencies, streamline, and build cohesion among all HHS agencies. These goals are appropriate. The RIW understands belt-tightening and why the Indian health system must continually transition to be more productive and effective. Because real buying power of the Indian health system has not kept pace with the growing beneficiary population, the IHS has been streamlining, reducing staff, and restructuring to make the belt fit for many years.

As alternatives, the RIW proposes internal IHS reforms that will benefit front-line delivery of services to Indian people (see Section 8). However, the IHS cannot focus solely on belt-tightening because this approach will not close the gap in services or eliminate health status disparities. In fact, to eliminate health disparities Indian health care services must be expanded. All restructuring savings derived from restructuring in the IHS are best reinvested into additional health care services to American Indian and Alaska Native people—a productive, not counter-productive approach.

The HHS proposes to consolidate the functions listed below. Some of these functions will be consolidated immediately into the HHS by the end of FY 2003. Others will be consolidated in FY 2004 and FY 2005.

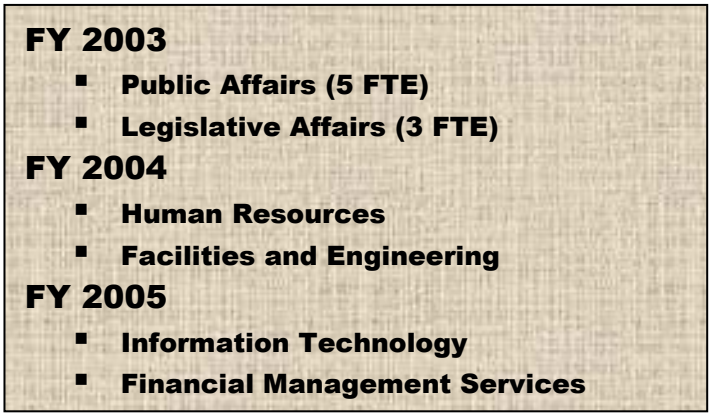

Figure 5.1, Consolidation Schedule Proposed by HHS

The RIW has identified the following concerns about consolidating IHS functions within HHS.

- The HHS consolidations will detract from the Government's responsibility to preserve Tribal sovereignty and will diminish services to the already underserved Indian population.
- The savings generated from the increased efficiencies predicted for One-HHS consolidation will not be reinvested in Indian health care.
- Characteristics unique to the Indian health system (Indian Preference, different budget and oversight committees in the Congress, Tribal shares, and how the system is based in hundreds of remote Indian communities – very different in structure, function and location from most HHS agencies) may not blend well with other HHS agencies lacking these characteristics.
- Resources consolidated from the IHS will be diluted, lose focus, and jeopardize the specialized experience and support relied on by the front-line, community-based health care system.
- The One-HHS consolidation proposals have not been sufficiently detailed to adequately evaluate their merit or impact. Without the details and Tribal consultation, the RIW is unable to conclude the best course of action and are reluctant to endorse One-HHS proposals because of this uncertainty.

Alternatives

The main concern of RIW members is that consolidation of IHS functions within HHS will reduce resources for Indian health and make the disparities and funding gap worse, not better. In light of this counter-productive result, the RIW suggests that HHS reconsider its consolidation proposals and explore alternative ways to achieve the goals for efficiency, savings, and cohesion.

Although not endorsing all of the One-HHS proposals, the RIW offers alternatives that will lessen their concerns and serve to creatively and constructively participate in the One-HHS initiative while resisting a loss of resources to Indian health. The alternatives are consistent with the President's and the Secretary's goals, but achieve them in ways that are less disruptive to the Indian health system.

Consolidation of IHS Public Affairs and Legislative Affairs Staff Offices

Consolidating IHS public affairs and legislative affairs within HHS means that the HHS proposes to transfer 8 FTEs ($779,000) from the IHS to the HHS. A primary objective for undertaking these consolidations is to ensure a more cohesive approach to legislation and public information among all the HHS agencies.

ADVANTAGES

- The staff will not physically relocate from the IHS headquarters office.
- Because they are physically remaining at IHS offices, they will maintain their immediate access to IHS leadership.
- The staff could be better connected to the HHS and raise the visibility of IHS issues and Indian Country's concerns.
- The staff could contribute to improved articulation of Indian health issues by HHS.

DISADVANTAGES

- The positions could lose their Indian Preference status.
- Tribal shares connected to the resources could be lost if they are not tracked.
- The IHS focus in staff assignments and work products could be diluted if the staff becomes absorbed in HHS work assignments and products.
- Responses to Indian Country could be delayed because it may take longer for clearance.

Tribal Leaders strongly oppose the transfer of the legislative affairs function. The IHS Legislative Affairs staff serves as a critical liaison to Congress, Tribal Governments, and Indian communities as well as between the IHS and the HHS administrations. To be effective, the staff must be closely connected with IHS administrative offices. Consolidating IHS Legislative Affairs has been discussed in many forums throughout Indian Country, and the response from Tribal Leaders is that this function should not be transferred from IHS. The HHS already closely supervises the IHS legislative staff for on-the-record activities. Why consolidate the IHS Legislative Affairs staff with other HHS legislative staffs when the IHS has separate congressional appropriations and, therefore, works with separate congressional oversight committees?

The RIW recommendations for Legislative and Public Affairs staffs are:

5.1 Maintain Legislative and Public Affairs staffs in IHS to ensure that HHS gets timely information from and well-informed analysis about Indian Country.

5.2 The IHS Legislation and Public Affairs staffs will coordinate closely with other HHS agencies in national emergencies and on cross-cutting issues to ensure cohesion of the HHS message.

5.3 Use performance contracts and inter-agency agreements to ensure IHS accountability to the Secretary for a cohesive approach to legislation and public information.

Consolidation of IHS Human Resources in HHS

The RIW was unable to evaluate the consolidation of the IHS human resources (HR) function within HHS because plans are still being formulated. The HHS-wide goal is to decrease the number of HR offices to four by the end of FY 2004. The RIW considered this goal, and looking through Indian Country lenses offers the following comments.

- Recruitment and retention of high-quality health care personnel throughout the Indian health care system is critical, especially in remote and isolated areas. Will the consolidations improve recruitment and retention and provide critical HR support functions in hundreds of health care locations in the Indian health system?
- A performance assessment of the HR within the IHS is appropriate. Realignment of selected HR functions could offer better support and higher levels of expertise.
- Consider whether outside sources could better perform some HR functions. As with all IHS functions, Tribes would have the first opportunity to contract for services formerly carried out by the IHS.
- With newer technologies and software, opportunities exist to further automate HR record-keeping, retrieval, and payroll.

Because IHS delivery systems are in rural and remote locations, it is not advantageous to consolidate HR with other HHS agencies.

- The IHS work force is composed of front-line health care providers and support staff, and is fundamentally different in character from the work force in most HHS agencies.
- Consolidating the HR function at a higher level in the HHS moves away from the front-lines of the Indian health system where the support is needed most.
- Human Resources functions and practices that work well in other HHS agencies, for example the scientific work force at the National Institute of Health and Centers for Disease Control and Prevention may not work well for a front-line health care delivery work force of 15,000 IHS employees in hundreds of sites in rural, isolated locations in Indian Country.
- The IHS operates under a unique law that applies Indian Preference in hiring and promotion practices. Most of the IHS work force (69 percent) are members of federally recognized Tribes. Their diverse cultures and traditions create a unique work force and work environment.
- A composite of HR staff from different HHS agencies can not ensure the specialized knowledge and skills needed to support the dispersed and remote locations of the IHS work force.

That Federal agencies become citizen-centered and results-oriented is easy to support. However, the proposed HR consolidations will not result in an agency more citizen-centered and more results-oriented. The recommendations for HR are:

5.4 Realign Human Resource (HR) support functions <u>within</u> IHS to take advantage of new technologies and enhance expertise available to all IHS sites in 35 States.

5.5 Avoid consolidating IHS' specialized experience and support for the dispersed community-based health care system with highly dissimilar agencies.

5.6 Implement operational improvements with the IHS to achieve performance goals envisioned by the Secretary.

Since the interim report was released, the RIW has explored internal reforms base on these recommendations for IHS human resources functions. A number of additional recommendations for improving administrative support, including human resources, are identified in Section 8.

Consolidation of Indian Health Facilities in HHS

The IHS is one of the few HHS agencies with a direct health care delivery mission; consequently, it has unique health-facility requirements. The IHS facilities' responsibilities, which American Indians and Alaska Natives depend on and which are part of the Federal Trust Responsibility, currently include safe drinking water and waste water disposal construction as well as the construction and maintenance of hospitals, clinics, health stations, staff quarters, and other ancillary buildings. These requirements deserve a specific focus connected to the Agency's unique mission.

Tribes, Congress, and the IHS have developed detailed processes for ascertaining facility needs, identifying priorities for health facilities construction, and determining methods for financing the design, construction, and maintenance of such facilities tailored to the unique challenges of the IHS operating environment. Consolidating Indian health facilities management into the HHS health facilities management process would unnecessarily complicate these processes.

The Secretary's concerns focus primarily on federal employee office buildings and facilities. The RIW has no objections to proposals regarding better coordination of federal office space. But, multi-agency facilities management offices are not advantageous for hundreds of IHS health delivery sites — many of which are in remote, rural locations.

- The consolidation with other HHS agencies will unnecessarily complicate the management of diverse and dissimilar facilities systems (i.e., the IHS facility construction priority-setting methodology, which is in response to congressional directives, may be compromised).
- Redirection of already inadequate facilities resources away from the growing backlog of construction and maintenance needs in Indian Country is counter-productive. (Approximately 30,000 Indian homes still lack either or both a safe water supply and adequate sewage disposal system. The IHS has identified a total backlog of 2,902 needed sanitation facilities construction projects costing $1.6 billion to provide all American Indians and Alaska Natives with safe drinking water and adequate waste disposal facilities in their homes.)
- There is strong opposition in Indian Country to merging the facilities programs into the HHS.

The RIW recommendations regarding consolidating IHS facilities within HHS are:

5.7 Retain the IHS health care facilities and sanitation construction programs within the IHS to ensure its mission-critical focus is maintained.
5.8 Endorse HHS steps to better manage federal office space that does not impact front-line Indian health care facilities.
5.9 Use a memorandum of agreement to ensure full reporting and compliance of IHS facilities data with HHS standards.
5.10 The HHS should support increased funding to address aged and inadequate health facilities in Indian Country.

Since the interim report was released in June 2002, the RIW has explored options for internal reforms of Indian health facility and engineering programs. Additional recommendations to improve facility and engineering support are identified in Section 8.

The President's Management Agenda

Many of the reforms and improvements proposed by the RIW for the Indian health system match principles in the President's Management Agenda for FY 2002.

"The President's vision for government reform is guided by three principles. Government should be:

- *Citizen-centered, not bureaucracy-centered;*
- *Results-oriented;*
- *Market-based, actively promoting rather than stifling innovation through competition."*[12]

The President's Management Agenda principles provide a useful framework for describing corresponding RIW principles for reforming the Indian health care system.

The President's Management Agenda Principles	Corresponding Principles for Reforming the Indian Health Care System
Citizen-Centered	**Patient-Centered** Tribes and Indian people participate in IHS reforms. IHS responds to the patients (citizens) it serves.
Results-Oriented	**Eliminate Disparities** Disparities in Indian health, access to services, and health care resources are eliminated
Market-Based	**Elective Outsourcing to Tribes** Tribes electively contract or compact for an increasing share of IHS programs.

Citizen-Centered Linkages—Continuous Consultation and Participation

The President's vision for a citizen-centered government corresponds with the RIW vision that "patient care comes first" and that Tribes and Indian people (citizens and customers) participate directly in shaping reforms and policies that affect their health care system. The RIW, a constituent-dominated workgroup, itself demonstrates stakeholder involvement in planning the Indian health care system.

Citizen-Centered in the context of Indian health also means a continuous process of consultation. Consultation with Tribes is both the policy of the Federal Government and an effective means for American Indian and Alaska Native citizens to shape the health program to meet their needs. Tribes and Indian people must continue to participate in reviewing all plans and policies that affect the IHS, Tribal, or urban Indian health programs.

The Indian concept of health involves traditional Tribal principles, culture, and heritage—a characteristic not found in mainstream American medical care. While the Indian health system shares some features with mainstream American health care systems, a truly citizen-centered approach will accommodate and respect unique Indian traditions of wellness and healing.

The following citizen-centered principles[13] have guided IHS reforms in recent years:

- Flexibility to serve diverse Indian communities, traditions, and cultures in differing creative ways.
- Decentralized decisions and shift of control to the local level where health care is delivered.
- Inclusion of Tribal and community participation.
- Shifting from overseeing front-line programs to supplying them with the services and technical assistance necessary to make them successful.

Results-Oriented Linkages—Eliminating Disparities

The RIW agrees with the President's Management Agenda focus on improving the performance of the Federal Government. His message:

> *"Government likes to begin things—to declare grand new programs and causes. But good beginnings are not the measure of success. What matters in the end is completion. Performance. Results. Not just making promises, but making good on promises."*

Health status of American Indians and Alaska Natives is among the lowest of All Americans (see the statistics in Section 3). American Indians and Alaska Natives agree with the President about expecting results. They expect results that assure adequate health care services are available to them. They expect results that eliminate disparities in their health compared to other Americans.

The President's phrase "making good on promises" resonates powerfully with Indian people. Indian people view federal promises of health care services to Indians as a historic obligation of the U.S. Government based on treaties which ceded millions of acres of land in exchange for federal services including health care. Making good on these promises is only possible with a substantial expansion of resources to American Indians and Alaska Natives.

Market-Based Linkages—Outsourcing and Tribal Choice

The President's goal for a market-based government corresponds to outsourcing of IHS programs to Tribes. Since 1980, the IHS has undergone a transformation. An exclusively federal system was transformed to a system in 2002 with more than half its programs operated by Tribal governments. The transformation will continue. Transfers of programs, resources and FTE to Tribes will continue as Tribes elect to contract or compact. This is one of the reasons that additional FTE cuts for IHS are unwise.

Electing to contract or not contract are both equal expressions of Tribal self-determination. Although several large Tribes are in the process of contracting for additional portions of the IHS, other Tribes have expressed their intention to retain a federally-operated health care program. Therefore, not all IHS programs are expected to be outsourced to Tribes.

In addition to Tribal contracts and compacts, the IHS purchases supplemental health care services that are impractical for the IHS to deliver directly. Approximately 15-20 percent of the IHS budget goes to purchasing health care services and supplies from the private sector.

There also are market-based distinctions unique to American Indians and Alaska Natives. One distinction compared to outsourcing with competitive bids is that Federal laws provide a right to Tribes to electively operate IHS programs with resources no less than the IHS would have used.

Tribal Self-Determination Rights

Self-determination rights must be assured regardless of the ways the Indian health care system is restructured:

5.11 Ensure that IHS reforms accommodate and affirm Tribal rights to compact, contract, or retain IHS to operate health programs directly.
5.12 Track all realigned resources to ensure that resources available to the Tribes (known as Tribal shares) are not reduced as consequence of reforms.
5.13 Apply all savings resulting from restructuring to additional health care services for Indian people.

After Tribes assume operation of their health programs, most continue to seek some technical assistance and other professional support services from the IHS. Not all technical support must come from traditional sources such as the IHS Area Offices. Technical assistance could be supplied from regional centers, Tribes, Tribal organizations, or Indian-owned and other specialty firms.

Some Tribes are reluctant to contract or compact IHS programs because of the additional costs for overhead incurred with the operation of the programs. The Indian Self-Determination Act authorizes payment for costs that a Tribal contract/compact incurs in addition to the transferred program resources. Contract support costs are currently funded at 86 percent of the total need. This is one reason that contracting has slowed in recent years.

5.14 Fully fund contract support costs and other one-time costs of transition to remove the impediment for additional Tribal contracting and compacting.

Specialized Units for a Mixed Environment

Given the mixed environment of tribal, urban, and IHS operated health programs, the IHS has developed specialized organizational units supporting each type. These units are: 1) the Office of Tribal Self-Governance specializes in self-governance compacts; 2) the Office of Tribal Programs specializes in self-determination contracts and more generally as liaison with Tribes; 3) a mixture of IHS offices specialize in IHS direct care programs; and 4) the Urban Indian Health Program specializes in Urban Indian health projects.

To assure IHS support from headquarters adapts to the changing mix of programs in the field, the RIW recommends:

5.15 Assess the structure and capacity of the Office of Tribal Programs, headquarters direct support programs, and the IHS Urban Indian Health Program Office to complement the assessment already completed for the Office of Tribal Self-Governance.
5.16 Assure a balanced capability among these offices in accordance with the actual mix of self-determination contracts and compacts, IHS direct programs, and Urban Indian Health Programs.
5.17 Identify contingency plans to minimize service disruptions for any tribe potentially affected by retrocession of a contract or compact to the IHS.
5.18 Manage transfer of Tribal shares to ensure a smooth and orderly transition of programs, activities, functions, and services to all Tribes.